Is Refusal to Treat Vaccine-Hesitant Families the Sanders-Red Hen of Medical Practice?

By Jamie Wells, M.D. — June 27, 2018

The account of the Virginia-based Red Hen restaurant owner insisting Press Secretary Sarah Sanders leave the premises due to presumed political differences has been playing on a loop of social and mainstream media punditry. This got me thinking about a recent sea change within distinct segments of the medical community when it comes to refusing to allow vaccine-hesitant families as patients at certain practices. The American Academy of Pediatrics (AAP) [2] has gone as far as sanctioning pediatricians kicking them out of a practice by making it official policy that this action can be used as an absolute last resort (see here [2]).

I consider these efforts misguided, serving more to alienate than inform. In the end, in my vast experience as a proponent of vaccination and a pediatrician who has administered without hesitation countless vaccines and counseled innumerable families on the topic, “us vs them” and “pro or anti” characterizations merely widen the gap not bridge it. Such tactics never influenced hearts and minds, only approaches through an empathetic lens coupled with mutual respect and civility moved the needle. For those on the fence, such absolutes do not accurately reflect their beliefs or the heterogeneous nature of their concerns. Shaming efforts and isolation serve merely to undermine the well-intended pediatric professionals and perpetuate a confirmation bias for this fearful sector that coercive measures are at the core of pushing so-called Big Vaccine.

The Sanders-Red Hen debate is politically driven, whereas medicine and its practice should be immune to such motivations. Doctors treat all personalities, persuasions, partisans, you-name-it and as a matter of principle and the fundamental tenets of bioethics their care delivery should never stray from the highest degrees of excellence, distinct from judgment or disparate personal
philosophies and irrespective of a patient’s identity or values (care should never be reduced or impacted by any of these similarities or differences).

There have been a number of deleterious consequences to such absolutism, including but not limited to losing a captive audience to educate on vaccine safety and benefits, co-opting the already diminishing time in a doctor’s office visit for the subject at the expense of other existing medical conditions, creating an impediment to shared decision making, subverting patient autonomy which is a slippery slope that can erode the doctor-patient relationship and bond formed. A just published opinion piece in *JAMA Pediatrics* [3] argues the dismissal of vaccine-refusing families results in many issues for clinicians not the least of which is “redistribute burdens of care,” foisting your problem patients onto others, thereby also sabotaging “professional solidarity.”

What is the end game with normalizing the dismissal of a patient who refuses vaccination? Is disagreement with a physician’s considered judgment grounds for dismissal. A patient-centered practice means the bioethical principles of beneficence, non-maleficence and personal autonomy are honored throughout the totality of care. These concepts are the foundation of the doctor-patient relationship. Isolating vaccine hesitancy from all other disagreements we can seems to miss the point, allowing paternalism [4] of the “physician knows best” to creep back into the conversation.

Compelling people to do things against their will has a tendency not to work out too well. Where do we draw the line? Should we apply the same standards to those patients who continue to smoke or decline surgical care? Are all other important aspects of a pediatric visit, ensuring proper development, child safety or managing active disease, worth being sacrificed to make a point about how we vehemently disagree?

A multidisciplinary team from Texas just published their work in *PLOS Medicine* [5] on U.S. vaccination rates in children, specifically focusing on nonmedical exemptions (NMEs) in states and counties. In it, they acknowledge the role of the pediatrician is essential to minimizing NME rates and communication between these stakeholders has demonstrated tremendous effectiveness with vaccine compliance. But, they fail to address how time-intensive such frequent, cumulative discussions are for the typical busy practitioner. Additionally, they show there is a lack of homogeneity in such rates throughout states. This makes targeted regional approaches to hotspot zones (and counties with lower compliance) seem to be the more effective primary strategy (see here [6]).

It’s time to consider the big picture in our health policies. Vaccination rates do not improve when care is reduced and one-on-one conversations with an informed provider are eliminated. Freeing up the nonsense that consumes a physician’s time (e.g. mounting clerical burdens) during the busy office day to develop trusted relationships yields way more positive dividends in the compliance battle, and for way more than vaccines (see recent court battle on informed consent here [7]).

Shouldn’t we be focusing on these more constructive efforts? If the goal is guaranteeing the safety of children and the general population be protected from infectious disease, then why is shaming
playing any role?


Links
[1] https://upload.wikimedia.org/wikipedia/commons/2/2f/Sarah_Huckabee_Sanders_screenshot_2.png
[4] https://www.acsh.org/news/2018/05/01/are-we-actually-more-paternalistic-or-patient-centered-these-days-12904